Volume 5, Issue 1 January 2012

Welcome to the newsletter for the CaPSNIG
(Canadian Pediatric Surgical Nurses Interest Group)

Purpose of the CaPSNIG is to network and exchange information.
There is no cost to join the CaPSNIG group.
To join the list, please send a brief email to monping.chiang@sickkids.ca .
Make sure to include your full name, hospital/employer, area of expertise, and preferred email address.
Please let us know if it's okay to share your email address with the rest of the group, since each hospital in Canada has different communication channels and confidentiality rules.

Chair Monping Chiang, RN(EC), MS, FNP-C
Nurse Practitioner-Pediatrics
Co-chair Christina Kosar; NP Pediatrics
Hospital for Sick Children, GIFT program

Nominations are open for co-chair for next year.

Annual Meeting September 20, 2012
Victoria, British Columbia, Canada

more information at http://www.caps.ca/

Call for Oral or Poster Presentations
2012 8th Annual CaPSNIG Conference

This is the call for abstracts for the 8th annual meeting of the Canadian Pediatric Surgical Nurses Interest Group (CaPSNIG) to be held **September 20, 2012 in Victoria, British Columbia**.

Everyone submitting an abstract must complete all information requested. After the form is completed and sent, you will receive confirmation via email that you submission has been received.

Eligibility
Abstracts for presentation are welcome in any subject in clinical and experimental pediatric general surgery including interesting cases, research outcomes, and tips in management of challenging cases.

Deadline
April 13th, 2012

Criteria for Abstracts:
1) Length is limited to 300 words, single-spaced, 10 pt, Arial font. (separate word document)
2) Include authors name and credentials, title of position and institution, contact information, and a brief biography. (attached form, separate from abstract document)
3) Specify if you are applying for oral or poster presentation.
4) Specify the abstract category you are applying for (i.e., Practice abstract, Case study abstract, or Research abstract)
5) The format outlined below should be utilized

For Practice Abstracts

1. Background: Include a description that identifies the problem and need for the practice change or innovation.
2. Objective: Clearly state the objective for the practice innovation.
3. Outcomes: Describe the outcomes. Indicate the key measures or indicators used to evaluate the outcomes.
4. Conclusion

For Case Study Abstracts

1. Statement of Clinical Problem: Articulate clearly the clinical problem relevant to pediatric surgical nursing. Include relevant clinical data such as age, gender, primary related diagnosis, and relevant comorbidities.
2. Description of Past Management: Include a description of the duration of the clinical problem, past management approaches, and patient response.
3. Current Clinical Approach: Describe the changes made to the management plan along with a rationale.
4. Patient Outcomes: Describe the patient response including time frame for response, objective and subjective data.
5. Conclusions: Identify clinical implications along with limitations.

For Research Abstracts
1. Background: Provide context/background to the need for the study and the significance of the problem
2. Research Question/Purpose
3. Methods: Describe the study design and data collection, including number and characteristics of subjects studied and the strategies used to recruit them. What are the outcomes measures?

4. Results
5. Implications for practice and conclusion

Notification
The authors will be informed of the status of their submission by May 14th, 2012.

Categories
Oral presentations will be 20 minutes in length.
Poster authors or designees must be present with the poster during meeting and prepared to give a 5-10 minute oral presentation of the poster.

Format
Presentations must be in Powerpoint format.
Presentations must be submitted to Christina Koscar on CD or memory stick on September 20, 2012.

Presenters are responsible for conference fees, lodging and travel. Please go to the CAPS website for further information (www.caps.ca)

Please fill out attached demographic form and submit abstract by April 13th, 2012 to:
Monping Chiang @ (monping.chiang@sickkids.ca)

CaPSNIG Presenter Bio form-Oral or Poster Presentations

TITLE OF PRESENTATION: _____

PRESENTERS NAME: _____

CREDENTIALS: _____

TITLE OF POSITION: _____

INSTITUTION OF EMPLOYMENT: _____

CONTACT INFORMATION

PHONE #: _____

EMAIL: _____

BRIEF BIOGRAPHY FOR INTRODUTION PURPOSES:

Clinical Corner January 2012

Q: I'm wondering if your facility has a policy for BLSC

A: Our policy at Sickkids requires RNs to submit proof of BCLS certification every 2 years. Also note that if the RN has PALS training, this supersedes BCLS training (Toronto)

A: our target at the Montreal Children's is that all new nurses should attend as part of orientation to the hospital. It is expected that all nurses be recertified every two years (Montreal)

A: BLS is no longer mandatory at our centre and no longer provided by our facility (Winnipeg)

A: Our nurses are required to recertify yearly as well for annual competency requirements (BC Children)

A: Our nurses are required to recertify every year as part of their annual competency requirements. (Alberta)

Q: I am wondering if others have used Cholestyramine in a cream form for perineal skin excoriation in short gut/ostomy closure (or other) babies. We have been using it here, and it works beautifully, otherwise, any other fantastic tips on horrific incontinence associated skin excoriation?

A: We sometimes use Cholestyramine in combination with Aquaphor and Sulcrate (Brisseau's Butt Paste) and it works as well as anything else.
A lot has to do with how these products are used and how the area is cleansed. It is very easy to fall into the trap of trying one product for a day, and then switch to something else because it isn't working.

A: We use the stoma powder as well on open sores, just tap a little bit and then cover with diaper cream. We like Ihle's paste which is cheap and thick. We will sometimes mix the Ihle's paste and stoma powder together to make a thicker cream if the diaper cream has disappeared with each diaper change. Some children use the Coloplast Triad Hydrophilic paste but it is very expensive. I recommend a daily bath as well to make sure the area is being soaked and not using commercial diaper wipes as they can sometimes be a bit irritating. Also to dab away the stool at each diaper change and not try to scrub off all the cream. Calmoseptine can also work really nicely with some families.
I also examine diet – does the child take a lot of sugar (natural or in processed foods), is lactose an issue for them, can they bulk stools with Metamucil (100% psyillium)? Sometimes if the families cut out sugar and lactose this helps slow down stool output which improves the diaper rash.

A: We do use Cholestyramine especially when children are on Ranitidine, Prevacid

Q: Next up is Ilex Paste or skin barrier protectant. I have a couple of families that use this and swear by it. It is not regulated or licensed in Canada, and therefore we are unable to try it ourselves, but does anyone else have families who order this product? It appears to be quite impressive, this baby had total colonic HD and has not diaper rash, not even any redness

A: My experience with these products is that you have to look at the ingredients. Ilex contains cortisone which is not good for long-term use. What is good about it is the Karaya gum powder which will provide it

with the ability to adhere to moist tissue. If the child has a chronic long-standing diaper dermatitis this may help in the short term but the family should be made aware that cortisone is not a good option to use for a long time.

A: I do have families that go to the States to get Ilex cream, and I think most kids in the States do use this from what I understand.

Q: I have a patient who is on a long term medication patch. The adhesive on the patch is causing skin breakdown. Does anyone have any suggestions for how to best manage this? Discontinuing the dose/delivery of the patch/medication is not an option as we are willing to accept the broken down skin as the benefits far outweigh the skin irritation.

Thoughts I had but decided against are:
1. Cavilon - except that we are concerned that would impact the delivery of the medication in the patch.
2. A barrier cream - would impede the adhesive in the patch from adhering and also impede medication delivery.
3. Hydrocortisone for trt of the areas after the patch has been removed and repositioned (what is currently being suggested/trialed).
Anything I have missed? Or does anyone have any other thoughts ideas or suggestions?

A: Wondering if the patch has a sticky border where you could swab the border with Cavilon swabs. Then the medicine is in the middle of the patch for delivery?? The NICU nurse here suggests not using the adhesive portion. Perhaps wrapping the patch on a limb with COBAN – an elastic wrap. NICU uses it for keeping oxygen probes in place. Otherwise we agree, rotating sites and steroid cream and time to allow healing in between.

A: Would it be possible to cover the adhesive portion of the patch either with the original wrapper or other, leaving a hole of the medication portion. Could then a tegaderm be used to cover the entire patch in place without the adhesive contacting the skin?

Q: Does anyone have written guidelines for re-feeding through a mucous fistula in neonates?

A: Protocol for Mucous Fistula Refeeding was provided BC Children's Hospital


NICU -MUCOUS FISTULA REFEEDINGS


NICU Ostomy Worksheet for.doc

Q: Recently we seem to be booking doing more ACE procedures. I am trying to pull some resources for cecostomy care guidelines for both families and professionals. Just wondering what guidelines others are using

A: We also use the booklet provided by Cook and this is given to every family. On discharge they are also given a much briefer pamphlet (that is still in draft but being used) that contains the highlights of discharge instructions (which I have attached). How many of you are using MicKeys instead of the "Trapdoor"? Any breakthroughs on transitioning these kids into the adult world. We are having some success with the SB population but still struggling with the rest.

Discharge instructions C tube.dc

A: McMaster provided a teaching pamphlet

CecostomyTubePOR TRAIT-lw.pdf

A: Victoria General Hospital provided

Temp and Chait Trapdoor Cecostomy

A: Winnipeg Children's Hospital

30.35.01b_HavingaCecostomy_2011.pdf

A: For professionals we have created a clinical pathway to guide care while in hospital. Otherwise there is a dietician and an nurse from interventional radiology who work with these families to ensure enema regimen is working and tube being changed yearly.

Q: I am currently revising our rectal irrigation protocol for the treatment of Hirshprung's associated enterocolitis because there has been a few issues.

A: Protocol was provided by IWK Health Center

Bowel Rectal Irrigations September

PL-0271 Rectal Irrigation.doc

A: We use a 12 Fr foley for the infants QID alternating with a Hagar dilator for decompression as needed. We use 10 mL/kg of NS warmed. (although when I have to do aggressive irrigations in the day unit b/c kids are bunged up I use whatever I need to use to be successful). We insert and inject. We have a surgeon who likes to allow passive drainage of fluid out and some will aspirate the catheter tip syringe that's attached to the foley. I find success depends on how sticky the stool is. We also encourage changing babes position, side to side, occ prone – depending how bunged up they are. We use a 14Fr str cath with slightly older infants. For young children that have issues post pull thru I find a 24-28Fr chest tube quite effective. We send it home with parents for PRN irrigations. I insert gently until resistance.

Q: Because of one conversation regarding taped report I have brought the proposal forward to our Nursing Practice Committee for changing to "face to face" reporting. They are interested in any processes that are in current use for consideration here. They are curious about the logistics of it when you have 5 patients and not always signing over to the same nurse.

A: At ACH, we used to do morning and evening taped report and it actually worked really well. The charge nurse would speak to each nurse usually 1 hour before shift change, get the pt update and then the charge nurse would record the taped report. Then, the new shift would come on and listen to the entire report for all the pts. As a group, we found this incredibly useful in knowing what was happening with all the patients (i.e. pt. acuity, difficult families, procedures, etc).
For 1:1 or very sick pts, the 2 nurses would have often get individual face-face report.
Another idea, is to have the out-going shift nurses individually come into the report room and discuss their patients with all the nurses.
Of course both ideas require a room or "area" where this could be done

St John's, NFLD. 2007

Toronto, ON. 2008

Halifax, NS. 2009

Saskatoon, SK. 2010

Ottawa, ON. 2011

See you in Victoria!